EMERGENCY MEDICAL TECHNICIAN-INTERMEDIATE/85

TRAINING PROGRAM APPLICATION

North Dakota Department of Health

Division of Emergency Medical Services
600 East Boulevard Avenue Dept 301
Bismarck ND 58505-0200
(701) 328-2388

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF EMERGENCY MEDICAL SERVICES
600 EAST BOULEVARD AVENUE DEPT 301 BISMARCK ND 58505-0200
(701) 328-2388

EMERGENCY MEDICAL TECHNICIAN-INTERMEDIATE/85
TRAINING PROGRAM APPLICATION

PLEASE PRINT OR TYPE

Person Completing Application _____

Address _____

City _____ State _____ Zip Code _____

Phone _____

Agency Hosting Program _____

Address _____

City _____ State _____ Zip Code _____

Phone _____

Location of Classes _____

Address _____

City _____ State _____ Zip Code _____

Course Starting Date _____ Proposed Ending Date _____

Number of Didactic Hours _____ Number of Clinical Hours _____

Maximum Number of Students Accepted _____ Tuition Fee _____

Primary Text _____

Publisher _____

Additional Text _____

Publisher _____

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF EMERGENCY MEDICAL SERVICES
600 EAST BOULEVARD AVENUE DEPT 301 BISMARCK ND 58505-0200
(701) 328-2388

EMERGENCY MEDICAL TECHNICIAN-INTERMEDIATE/85
COURSE COORDINATOR AGREEMENT

PLEASE PRINT OR TYPE

I _____
(Name of NREMT-I, NREMT-P, RN, or Physician)

of _____
(Street/Box #, City, State, Zip Code)

agree to act as the course coordinator for the _____ EMT-Intermediate/85 Training Program.

I UNERSTAND AND AGREE TO THE FOLLOWING:

- I recognize that my responsibilities are, but not limited to the following:
    - To work under the supervision of the Medical Training Director.
    - Complete and submit the course application forms prior to the start of the course.
    - Arrange for training facilities and materials.
    - Arrange for hospital and field clinical experience with appropriate supervision.
    - Be responsible for the selection and orientation of clinical preceptors.
    - Establish course schedules.
    - Maintain attendance, evaluation and examination records for each student.
    - Schedule instructors and provide them with the material necessary to complete the instruction.
    - Perform other tasks as assigned by the Medical Training Director.

_____ _____
Date Signature of Course Coordinator

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF EMERGENCY MEDICAL SERVICES
600 EAST BOULEVARD AVENUE DEPT 301 BISMARCK ND 58505-0200
(701) 328-2388

EMERGENCY MEDICAL TECHNICIAN-INTERMEDIATE/85
MEDICAL TRAINING DIRECTOR AGREEMENT

PLEASE PRINT OR TYPE

I _____
(Name of Physician)

of _____
(Street/Box #, City, State, Zip Code)

agree to act as the course coordinator for the _____ EMT-Intermediate/85

Training Program.

IN THIS CAPACITY, I REALIZE MY REPONSIBILITIES ARE AS FOLLOWS:

- Obtain approval from the hospital medical staff(s) (providing clinical training) to initiate an Intermediate/85 course.
- Assure overall direction and coordination of the planning, organization, administration, periodic review, continued development and effectiveness of the program.
- Oversee that the course is conducted as outlined in the curriculum.
- Oversee the quality of instruction and clinical experience.
- Oversee course compliance with all applicable board regulations.
- Critique patient care during training and assure maintenance of written documentation of same.
- Participate in review of student applications and selection.
- Review results of interim examinations.

_____ _____
Date Signature of Medical Training Director

SFN 17390(11/90,R04/96,R02/05)

_____
License Number

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF EMERGENCY MEDICAL SERVICES
600 EAST BOULEVARD AVENUE DEPT 301 BISMARCK ND 58505-0200
(701) 328-2388

EMERGENCY MEDICAL TECHNICIAN-INTERMEDIATE/85
HOSPITAL ADMINISTRATION SUPPORT OF EMT-INTERMEDIATE/85 TRAINING PROGRAM

PLEASE PRINT OR TYPE

As administrator of _____
(Name of Hospital)

I support the initiation of an EMT-Intermediate/85 Training Program and agree that the students enrolled in this program may do their clinical training skills in this hospital.

_____	_____
Printed Name of Hospital Administrator	Signature of Hospital Administrator
_____	_____
Name of Hospital	Phone Number of Hospital Administrator
_____	_____
Address of Hospital	Date

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF EMERGENCY MEDICAL SERVICES
600 EAST BOULEVARD AVENUE DEPT 301 BISMARCK ND 58505-0200
(701) 328-2388

EMERGENCY MEDICAL TECHNICIAN-INTERMEDIATE/85
ALS AMBULANCE SERVICE SUPPORT OF EMT-INTERMEDIATE/85 TRAINING PROGRAM

As director of _____
(Name of Ambulance Service)

I agree to provide a setting for conducting the ALS Ambulance Clinical for the EMT-Intermediate/85 Training program to be held at _____
(Name of City)

I understand the ALS ambulance experience will involve the EMT-Intermediate/85 students observing and participating under supervision in all aspects of patient care as carried out by this service. The ambulance Clinical experience will be under the supervision of the EMT-Intermediate/85 Medical Training Director listed here _____
(Name of Medical Training Director)

_____ _____
Printed Name of Ambulance Service Director Signature of Ambulance Service Director

_____
Date